

IMPORTANT: Read Instructions on bottom of Certification Page before completing this Form. Failure to comply with instructions may cause disapproval of proposed Regulations.

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REGULATION
OF

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NAME OF AGENCY
INSURANCE DEPARTMENT

Concerning

SUBJECT MATTER OF REGULATION

Medicare Supplement Insurance Minimum Standards

Sec. 1. Subsection (k) of Section 38a-495a-2 of the Regulations of Connecticut State Agencies is amended to read as follows:

(k) "Medicare+choice plan" means a plan of coverage for health benefits under Medicare part C as defined in [section 1859 found in title iv, subtitle a, chapter 1 of p.l. 105-33,] 42 USC 1395w-28(b)(1), and includes:

- (1) Coordinated care plans which provide health care services, including but not limited to health care center plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;
- (2) Medical savings account plans coupled with a contribution into a Medicare+choice medical savings account; and
- (3) Medicare+choice private fee-for-service plans.

Sec. 2. Subdivision (7) of Subsection (a) of Section 38a-495a-5 is amended to read as follows:

(7)(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(C) EACH MEDICARE SUPPLEMENT POLICY OR CERTIFICATE SHALL PROVIDE THAT BENEFITS AND PREMIUMS UNDER THE POLICY OR CERTIFICATE SHALL BE SUSPENDED (FOR ANY PERIOD THAT MAY BE PROVIDED BY FEDERAL REGULATION) AT THE REQUEST OF THE POLICYHOLDER OR CERTIFICATEHOLDER IF THE POLICYHOLDER OR CERTIFICATEHOLDER IS ENTITLED TO BENEFITS UNDER SECTION 226(b) OF THE SOCIAL SECURITY ACT AND IS COVERED UNDER A GROUP HEALTH PLAN (AS DEFINED IN SECTION 1862(b)(1)(A)(v) OF THE SOCIAL SECURITY ACT). IF SUCH SUSPENSION OCCURS, AND IF THE POLICYHOLDER OR CERTIFICATEHOLDER LOSES COVERAGE UNDER THE GROUP HEALTH PLAN, THE POLICY OR CERTIFICATE SHALL BE AUTOMATICALLY REINSTITUTED (EFFECTIVE AS OF THE DATE OF LOSS OF SUCH COVERAGE) IF THE POLICYHOLDER OR

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CERTIFICATEHOLDER PROVIDES NOTICE OF LOSS OF COVERAGE WITHIN 90 DAYS AFTER THE DATE OF SUCH LOSS OF COVERAGE.

[(C)] (D) Reinstitution of [such coverages:] COVERAGE AS DESCRIBED IN SUBPARAGRAPHS (B) AND (C) OF THIS SUBDIVISION:

- (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
- (ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of suspension; and
- (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

Sec. 3. Subdivision (5) of subsection (b) of Section 38a-495a-5 of the Regulations of Connecticut State Agencies is amended to read as follows:

(5) Coverage for the coinsurance amount, [(i) or in the case of hospital outpatient department services[,]] PAID UNDER A PROSPECTIVE PAYMENT SYSTEM, the copayment amount, [(i)] of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Sec. 4. Subdivision (9) of subsection (c) of Section 38a-495a-5 is amended to read as follows:

(9) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (B) OF THIS SUBDIVISION and patient education to address preventive health care measures.

(B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) [Fecal occult blood test and/or digital] DIGITAL rectal examination;

[(ii) Mammogram;]

[(iii)] (iii) Dipstick urinalysis for hematuria, bacteriuria and [proteinuria;] PROTEINURIA;

[(iv)] (iii) Pure tone (air only) hearing screening test, administered or ordered by a physician;

[(v)] (iv) Serum cholesterol screening (every five (5) years);

[(vi)] (v) Thyroid function test;

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[(vii)] (vi) Diabetes screening.

(C) [Influenza vaccine administered at any appropriate time during the year and] Tetanus and Diphtheria booster (every ten (10) years).

(D) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

Sec. 5. Subsection (a) of Section 38a-495a-7 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) (1) [In the event that this State shall become a Medicare Select State, this] THIS section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

Sec. 6. Section 38a-495a-8a is amended to read as follows:

(a) Guaranteed Issue

(1) Eligible persons are those individuals described in subsection (b) of this section who [apply] SEEK to enroll under the policy [not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (b).] DURING THE PERIOD SPECIFIED IN SUBSECTION (c) OF THIS SECTION, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection [(c)] (e) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) Eligible Persons

An eligible person is an individual described in any of the following subdivisions:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan

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ceases to provide all such supplemental health benefits to the individual;

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply, [:] OR THE INDIVIDUAL IS 65 YEARS OF AGE OR OLDER AND IS ENROLLED WITH A PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PROVIDER UNDER SECTION 1894 OF THE SOCIAL SECURITY ACT, AND THERE ARE CIRCUMSTANCES SIMILAR TO THOSE DESCRIBED BELOW THAT WOULD PERMIT DISCONTINUANCE OF THE INDIVIDUAL'S ENROLLMENT WITH SUCH PROVIDER IF SUCH INDIVIDUAL WERE ENROLLED IN A MEDICARE+CHOICE PLAN;

(A) [The organization's or plan's certification (under this part) has been terminated] THE CERTIFICATION OF THE ORGANIZATION OR PLAN HAS BEEN TERMINATED or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(B) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(C) The individual demonstrates, in accordance with guidelines established by the Secretary, that: (i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) The individual meets such other exceptional conditions as the Secretary may provide.

(3) (A) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 OF THE SOCIAL SECURITY ACT (Medicare [risk or] cost);

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- (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
 - (iii) An organization under an agreement under Section 1833(a)(1)(A) OF THE SOCIAL SECURITY ACT (health care prepayment plan); or
 - (iv) An organization under a Medicare Select policy; and
- (B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (2) OF THIS SUBSECTION.
- (4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
- (A) (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or
 - (ii) Of other involuntary termination of coverage or enrollment under the policy;
 - (B) The issuer of the policy substantially violated a material provision of the policy; or
 - (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
- (5) (A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 OF THE SOCIAL SECURITY ACT (Medicare [risk or] cost), any similar organization operating under demonstration project authority, [an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan),] ANY PACE PROVIDER UNDER SECTION 1894 OF THE SOCIAL SECURITY ACT, or a Medicare Select policy; and
- (B) The subsequent enrollment described in subparagraph (A) OF THIS SUBDIVISION is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or
- (6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare+Choice plan under part C of Medicare, OR WITH A PACE PROVIDER UNDER SECTION 1894 OF THE SOCIAL SECURITY ACT, and disenrolls from the plan OR PROGRAM by not later than twelve (12) months after the effective date of enrollment.

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SECTION 1**(c) GUARANTEED ISSUE TIME PERIODS**

(1) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBDIVISION (1) OF SUBSECTION (b) OF THIS SECTION, THE GUARANTEED ISSUE PERIOD BEGINS ON THE DATE THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION OR CESSATION OF ALL SUPPLEMENTAL HEALTH BENEFITS (OR, IF SUCH NOTICE IS NOT RECEIVED, NOTICE THAT A CLAIM HAS BEEN DENIED BECAUSE OF SUCH A TERMINATION OR CESSATION) AND ENDS 63 DAYS AFTER THE DATE OF THE APPLICABLE NOTICE;

(2) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBDIVISIONS (2), (3), (5) OR (6) OF SUBSECTION (b) OF THIS SECTION WHOSE ENROLLMENT IS TERMINATED INVOLUNTARILY, THE GUARANTEED ISSUE PERIOD BEGINS ON THE DATE THAT THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION AND ENDS 63 DAYS AFTER THE DATE THE APPLICABLE COVERAGE IS TERMINATED;

(3) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBPARAGRAPH (A) OF SUBDIVISION (4) OF SUBSECTION (b) OF THIS SECTION, THE GUARANTEED ISSUE PERIOD BEGINS ON THE EARLIER OF: (A) THE DATE THAT THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION, A NOTICE OF THE ISSUER'S BANKRUPTCY OR INSOLVENCY, OR OTHER SIMILAR NOTICE IF ANY, AND (B) THE DATE THAT THE APPLICABLE COVERAGE IS TERMINATED, AND ENDS 63 DAYS AFTER THE DATE THE COVERAGE IS TERMINATED;

(4) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBDIVISION (2), (5) OR (6) OF SUBSECTION (b) OF THIS SECTION OR SUBPARAGRAPH (B) OR (C) OF SUBDIVISION (4) OF SUBSECTION (b) OF THIS SECTION WHO DISENROLLS VOLUNTARILY, THE GUARANTEED ISSUE PERIOD BEGINS ON THE DATE THAT IS 60 DAYS BEFORE THE EFFECTIVE DATE OF THE DISENROLLMENT AND ENDS ON THE DATE THAT IS 63 DAYS AFTER THE EFFECTIVE DATE; AND

(5) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBSECTION (b) BUT NOT DESCRIBED IN THE PRECEDING SUBDIVISIONS OF THIS SUBSECTION, THE GUARANTEED ISSUE PERIOD BEGINS ON THE EFFECTIVE DATE OF DISENROLLMENT AND ENDS ON THE DATE THAT IS 63 DAYS AFTER THE EFFECTIVE DATE.

(d) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS

(1) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBDIVISION (5) OF SUBSECTION (b) OF THIS SECTION (OR DEEMED TO BE SO DESCRIBED, PURSUANT TO THIS SUBDIVISION) WHOSE ENROLLMENT WITH AN ORGANIZATION OR PROVIDER DESCRIBED IN SUBPARAGRAPH (A) OF SUBDIVISION (5) OF SUBSECTION (b) OF THIS SECTION IS INVOLUNTARILY TERMINATED WITHIN THE FIRST 12 MONTHS OF ENROLLMENT,

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AND WHO, WITHOUT AN INTERVENING ENROLLMENT, ENROLLS WITH ANOTHER SUCH ORGANIZATION OR PROVIDER, THE SUBSEQUENT ENROLLMENT SHALL BE DEEMED TO BE AN INITIAL ENROLLMENT DESCRIBED IN SUBDIVISION (5) OF SUBSECTION (b) OF THIS SECTION;

(2) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBDIVISION (6) OF SUBSECTION (b) OF THIS SECTION (OR DEEMED TO BE SO DESCRIBED, PURSUANT TO THIS SUBDIVISION) WHOSE ENROLLMENT WITH A PLAN OR IN A PROGRAM DESCRIBED IN SUBDIVISION (6) OF SUBSECTION (b) OF THIS SECTION IS INVOLUNTARILY TERMINATED WITHIN THE FIRST 12 MONTHS OF ENROLLMENT, AND WHO, WITHOUT AN INTERVENING ENROLLMENT, ENROLLS IN ANOTHER SUCH PLAN OR PROGRAM, THE SUBSEQUENT ENROLLMENT SHALL BE DEEMED TO BE AN INITIAL ENROLLMENT DESCRIBED IN SUBDIVISION (6) OF SUBSECTION (b) OF THIS SECTION; AND

(3) FOR PURPOSES OF SUBDIVISIONS (5) AND (6) OF SUBSECTION (b) OF THIS SECTION NO ENROLLMENT OF AN INDIVIDUAL WITH AN ORGANIZATION OR PROVIDER DESCRIBED IN SUBPARAGRAPH (A) OF SUBDIVISION (5) OF SUBSECTION (b) OF THIS SECTION, OR WITH A PLAN OR IN A PROGRAM DESCRIBED IN SUBDIVISION (6) OF SUBSECTION (b) OF THIS SECTION, MAY BE DEEMED TO BE AN INITIAL ENROLLMENT UNDER SUBDIVISIONS (1) AND (2) OF THIS SUBSECTION AFTER THE 2-YEAR PERIOD BEGINNING ON THE DATE ON WHICH THE INDIVIDUAL FIRST ENROLLED WITH SUCH AN ORGANIZATION, PROVIDER, PLAN OR PROGRAM.

[(c)] (e) Products to Which Eligible [Person] PERSONS are Entitled
The Medicare supplement policy to which eligible persons are entitled under:

(1) Subdivisions (1), (2), (3) and (4) of subsection (b) OF THIS SECTION is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

(2) Subdivision (5) of subsection (b) OF THIS SECTION is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subdivision (1) OF THIS SUBSECTION.

(3) Subdivision (6) of subsection (b) OF THIS SECTION shall include any Medicare supplement policy offered by any issuer.

[(d)] (f) Notification provisions

(1) At the time of an event described in subsection (b) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a). Such notice shall be communicated contemporaneously with the notification of termination.

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(2) At the time of an event described in subsection (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Sec. 7. Subdivision (6) of subsection (a) of Section 38a-495a-13 is amended to read as follows:

(6) (A) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to [a person(s)] PERSONS eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered

(B) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

Sec. 8. Subdivision (4) of subsection (c) of Section 38a-495a-13 is amended to read as follows:

(4) The following items shall be included in the outline of coverage in the order prescribed below.

PREMIUM INFORMATION

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this State. [(If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features.

The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with our policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

(for agents:)

Neither (insert company's name) nor its agents are connected with Medicare.

(for direct response:)

(insert company's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult ["The Medicare Handbook"] THE Medicare & You HANDBOOK for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 38a-495a-6(d).)] FOR PURPOSES OF ILLUSTRATION, THE CHARTS BELOW DISPLAY IN PARENTHESES DOLLAR AMOUNTS THAT VARY IN ACCORDANCE WITH THE MEDICARE PROGRAM. ISSUERS SHALL REVISE SUCH DOLLAR AMOUNTS AS NECESSARY TO ENSURE THAT OUTLINES OF COVERAGE CONTAIN INFORMATION THAT IS CURRENT AT THE TIME THE OUTLINES ARE PROVIDED TO CONSUMERS.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.)

(Illustrative charts follow)

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Sec. 9. The illustrative charts that follow subsection (c) of Section 38a-495a-13 of the Regulations of Connecticut State Agencies are amended as follows:

PLAN A

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	[All but \$(764)] All but \$(812)	\$0	[\$(764) (Part A Deductible)] \$(812) (Part A Deductible)
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	[All but \$(191) a day] \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	[All but \$(382) a day] All but \$(406) a day \$0 \$0	[(382) a day] \$(406) a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 \$0 \$0	\$0 [Up to \$(95.50) a day] Up to \$(101.50) a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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SECTION 1

PLAN A

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible (will) WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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SECTION **1**PLAN **B**

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	[All but \$(764)] All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	\$(191) a day \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days	[All but \$(382) a day] All but \$(406) a day	\$(382) a day \$(406) a day	\$0
--Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	\$0 \$0	100% of Medicare Eligible Expenses \$0	\$0 ** All Costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 \$0 \$0	\$0 [Up to \$(95.50) a day] Up to \$(101.50) a day All costs
21st thru 100th day 101st day and after	\$0	\$0	\$0
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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PLAN B

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible [will] WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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SECTION 1

PLAN C

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	{All but \$(764)} All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	{All but \$(191) a day} All but \$(203) a day	\$(191) a day \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	{All but \$(382) a day} All but \$(406) a day \$0 \$0	\$(382) a day \$(406) a day 100% of Medicare Eligible Expenses \$0	\$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts {All but \$(95.50) a day} All but \$(101.50) a day \$0	\$0 \$(Up to \$(95.50) a day) Up to \$(101.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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PLAN C

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible [will] WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*	\$0	All Costs	\$0
Remainder of Medicare Approved Amounts	\$0	\$100 (Part B Deductible)	\$0
	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE			
Medically necessary emergency care services [beginning] BEGINNING during the first 60 days of each trip outside the USA	\$0	\$0	\$250
First \$250 each calendar year	\$0	80% to a lifetime max- imum benefit of \$50,000	20% and amounts over the \$50,000 lifetime (maximum) MAXIMUM
Remainder of charges			

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PLAN D

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	[All but \$(764)] All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	\$(191) a day \$(203) a day	\$0
91st day and after: -While using 60 lifetime reserve days	[All but \$(382) a day] All but \$(406) a day	\$(382) a day \$(406) a day	\$0
-Once lifetime reserve days are used: -Additional 365 days -Beyond the Additional 365 days	\$0 \$0	100% of Medicare Eligible Expenses \$0	\$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	[All but \$(95.50) a day] All but \$(101.50) a day	[Up to \$(95.50) a day] Up to \$(101.50) a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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SECTION 1

PLAN D

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[(continued)]

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SECTION 1

PLAN D [(continued)]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services (beginning BEGINNING during the first 60 days of each trip outside the USA)			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime max- imum benefit of \$50,000	20% and amounts over the \$50,000 lifetime [maximum] MAXIMUM

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SECTION 1

PLAN E

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	[All but \$(764)] All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	\$(191) a day \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	[All but \$(382) a day] All but \$(406) a day \$0 \$0	\$(382) a day \$(406) a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 \$(Up to \$(95.50) a day) Up to \$(101.50) a day 0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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SECTION 1**PLAN E****MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR**

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible (will) WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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SECTION **1**

PLAN E [(continued)]

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services (beginning) BEGINNING during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime (maximum) MAXIMUM
*PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and (diphtheria) DIPHTHERIA booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People With Medicare*.

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PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [(\$1500)] \$(1620) deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [(\$1500)] \$(1620). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] \$(1620) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] \$(1620) DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	[All but \$(764)] All but \$(812) [All but \$(191) a day] All but \$(203) a day [All but \$(382) a day] All but \$(406) a day \$0 \$0	[(764) (Part A Deductible)] [(812) (Part A Deductible)] [(191) a day] [(203) a day] [(382) a day] [(406) a day] 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 *** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 [Up to \$(95.50) a day] Up to \$(101.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

[(continued)]

*** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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SECTION 1

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible [w/it] WILL have been met for the calendar year.

**THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS PLAN F AFTER ONE HAS PAID A CALENDAR YEAR [(\$1500)] ~~\$(1620)~~ DEDUCTIBLE. BENEFITS FROM THE HIGH DEDUCTIBLE PLAN F WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE [(\$1500)] ~~\$(1620)~~. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES THE MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [(\$1500)] \$(1620) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [(\$1500)] \$(1620) DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$100%	\$0 \$0 0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[(continued)]

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SECTION 1

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] \$[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] \$[1620] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	 \$0 \$0 \$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] \$[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] \$[1620] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services [beginning] BEGINNING during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime max- imum benefit of \$50,000	 \$250 20% and amounts over the \$50,000 lifetime [maximum] MAXIMUM

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SECTION **1**PLAN **G**

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	[All but \$(764)] All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	\$(191) a day] \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days	[All but \$(382) a day] All but \$(406) a day	\$(382) a day] \$(406) a day	\$0
--Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	\$0 \$0	100% of Medicare Eligible Expenses \$0	\$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 \$(Up to \$(95.50) a day) Up to \$(101.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$0	Balance

** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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SECTION 1**PLAN G****MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR**

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible [will] WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 \$0 Generally 80% \$0	 \$0 Generally 20% \$80%	 \$100 (Part B Deductible) \$0 20%
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN G [(continued)]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE			
Medically necessary emergency care services (beginning BEGINNING during the first 60 days of each trip outside the USA)			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime max- imum benefit of \$50,000	20% and amounts over the \$50,000 lifetime [maximum] MAXIMUM

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SECTION 1

PLAN H

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	[All but \$(764)] All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	\$(191) a day) \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	[All but \$(382) a day] All but \$(406) a day \$0 \$0	\$(382) a day) \$(406) a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 (Up to \$(95.50) a day) Up to \$(101.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

STATE OF CONNECTICUT REGULATION OF

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SECTION 1

PLAN H

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible [will] WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 \$0 Generally 80% \$0	 \$0 Generally 20% \$0	 \$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$100 (Part B Deductible) \$0

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SECTION **1**

PLAN H [(continued)]

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services (beginning) BEGINNING during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime [maximum] MAXIMUM
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE First \$250 each calendar year Next \$2,500 each calendar year Over \$2500 each calendar year	\$0 \$0 \$0	\$0 50%--\$1,250 calendar year maximum benefit \$0	\$250 50% All costs

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SECTION 1

PLAN I

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	[All but \$(764)] All but \$(812)	\$(764) (Part A Deductible) \$(812) (Part A Deductible)	\$0
61st thru 90th day	[All but \$(191) a day] All but \$(203) a day	\$(191) a day \$(203) a day	\$0
91st day and after: --While using 60 lifetime reserve days	[All but \$(382) a day] All but \$(406) a day	\$(382) a day \$(406) a day	\$0
--Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	\$0 \$0	100% of Medicare Eligible Expenses \$0	\$0 ** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	\$0 [Up to \$(95.50) a day] Up to \$(101.50) a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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SECTION 1

PLAN I

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible [will] WILL have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	\$100 (Part B Deductible) \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[(continued)]

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SECTION 1

PLAN I [(continued)]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			Balance
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE			
Medically necessary emergency care services [beginning] BEGINNING during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime max- imum benefit of \$50,000	20% and amounts over the \$50,000 lifetime [maximum] MAXIMUM
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2500 each calendar year	\$0	\$0	All costs

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SECTION 1

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [(\$1500)] \$(1620) deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [(\$1500)] \$(1620). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [(\$1500)] \$(1620) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [(\$1500)] \$(1620) DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	 [All but \$(764)] All but \$(812) [All but \$(191) a day] All but \$(203) a day [All but \$(382) a day] All but \$(406) a day \$0 \$0	 [\$(764) (Part A Deductible)] \$(812) (Part A Deductible) \$(191) a day] \$(203) a day [\$(382) a day] \$(406) a day 100% of Medicare Eligible Expenses \$0	 \$0 \$0 \$0 \$0 *** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts [All but \$(95.50) a day] All but \$(101.50) a day \$0	 \$0 {Up to \$(95.50) a day} Up to \$(101.50) a day \$0	 \$0 \$0 All costs
BLOOD First 3 pints Additional amounts	 \$0 100%	 3 pints \$0	 \$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

(continued)

*** NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

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PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible (will) WILL have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year ((\$1500) \$(1620) deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are ((\$1500) \$(1620). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] \$(1620) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] \$(1620) DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, Inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$100%	\$0 \$0 0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

((continued))

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SECTION 1

PLAN J or HIGH DEDUCTIBLE PLAN J [(continued)]

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$(1620) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$(1620) DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts [HOME HEALTH CARE (cont'd)]	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1600	

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INSURANCE DEPARTMENT

SECTION 1

PLAN J or HIGH DEDUCTIBLE PLAN J ((continued))

PARTS A & B (continued))

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] \$(1620) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] \$(1620) DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services [beginning] BEGINNING during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime max- imum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime [maximum] MAXIMUM
EXTENDED OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE First \$250 each calendar year Next \$6,000 each calendar year Over \$6,000 each calendar year	\$0 \$0 \$0	\$0 50%--\$3,000 calendar year maximum benefit \$0	\$250 50% All costs
***PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and [diphtheria] DIPHTHERIA booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

*** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People With Medicare*.

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NAME OF AGENCY
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SECTION 1

Sec. 10. Sec. 38a-495a-19 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, AN EMPLOYEE GROUP HEALTH INSURANCE POLICY OR CERTIFICATE, or a policy or certificate issued by a health care center pursuant to a contract with the federal government, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy or certificate.

(b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, AN EMPLOYEE GROUP HEALTH INSURANCE POLICY OR CERTIFICATE, or a policy or certificate issued by a health care center pursuant to a contract with the federal government, which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Statement of purpose: To conform Connecticut's Medicare supplement insurance program with Balanced Budget Refinement Act, Ticket to Work and Work Incentives Improvement Act, and Benefits Improvement and Protection Act of 2000 amendments to OBRA 90, to further expand credit for prior coverage, and to make technical corrections.

CERTIFICATION

R-39 REV. 1/77

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Be it known that the foregoing:

☒ Regulations ☐ Emergency Regulations

Are:

☐ Adopted ☒ Amended as hereinabove stated ☐ Repealed

By the aforesaid agency pursuant to:

☒ Section 38a-495a of the General Statutes.

☐ Section _____ of the General Statutes, as amended by Public Act No. _____ of the _____ Public Acts.

☐ Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on, 6/25/2002 of the notice of the proposal to:

☐ Adopt ☒ Amend ☐ Repeal such regulations

(If applicable): ☐ And the holding of an advertised public hearing on _____ day of _____ 20 _____

WHEREFORE, the foregoing regulations are hereby:

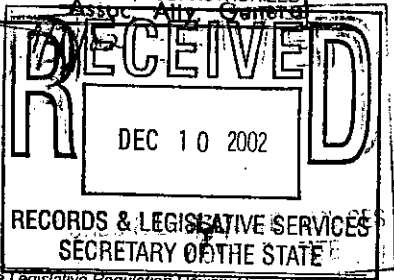
☐ Adopted ☒ Amended as hereinabove stated ☐ Repealed

Effective:

☒ When filed with the Secretary of the State.

(OR)

☐ The _____ day of _____

In Witness Whereof:	DATE <u>8/2/01</u>	SIGNED (Head of Board, Agency or Commission) <u>Susan F. Cogswell</u>	OFFICIAL TITLE, DULY AUTHORIZED INSURANCE COMMISSIONER
Approved by the Attorney General as to legal sufficiency In accordance with Sec. 4-169, as amended, C. G. S. :		SIGNED <u>Will B. Rell</u>	OFFICIAL TITLE, DULY AUTHORIZED Assoc. Atty. General
<input checked="" type="checkbox"/> Approved			
<input type="checkbox"/> Disapproved			
<input type="checkbox"/> Disapproved in part, (Indicate Section Numbers disapproved only)			
<input type="checkbox"/> Rejected without prejudice.			
By the Legislative Regulation Review Committee in accordance With Sec. 4-170, as amended, of the General Statutes.		DATE <u>11/26/02</u>	SIGNED (Clerk of the Legislative Regulation Review Committee) <u>Camela B. Booth</u>
Two certified copies received and filed, and one such copy forwarded to the Commission on Official Legal Publications In accordance with Section 4-172, as amended, of the General Statutes.			
DATE	SIGNED (Secretary of the State.)		BY

INSTRUCTION

- One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
- Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
- Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capitol letters and deleted language in brackets. Section 4-170 of the General Statutes